Complete Summary

GUIDELINE TITLE

Practice parameter for the assessment and treatment of children and adolescents with substance use disorders.

BIBLIOGRAPHIC SOURCE(S)

Work Group on Quality Issues. Bukstein OG. Practice parameter for the assessment and treatment of children and adolescents with substance use disorders. Washington (DC): American Academy of Child and Adolescent Psychiatry (AACAP); 2004. 25 p. [112 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Practice parameters for the assessment and treatment of children and adolescents with substance abuse disorders. J Am Acad Child Adolesc Psychiatry 1997 Oct;36(10 Suppl):140S-56S.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory information has been released.

- *On September 29, 2005, The U.S. Food and Drug Administration (FDA) directed Eli Lilly and Company (Lilly), the manufacturer of Strattera (atomoxetine), to revise the prescribing information to include a boxed warning and additional warning statements that alert health care providers of an increased risk of suicidal thinking in children and adolescents being treated with this medication. FDA also informed Lilly that a Patient Medication Guide (MedGuide) should be provided to patients when Strattera is dispensed. The MedGuide advises patients of the risks associated with and precautions that can be taken when Strattera is dispensed. Further, pediatric patients being treated with Strattera should be closely observed for clinical worsening, as well as agitation, irritability, suicidal thinking or behaviors, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases. See the FDA Web site.
- On October 15, 2004, the U.S. Food and Drug Administration (FDA) issued a Public Health Advisory, asking manufacturers of all antidepressant drugs to revise the labeling for their products to include a boxed warning and expanded warning statements that alert health care providers to an increased

risk of suicidality (suicidal thinking and behavior) in children and adolescents being treated with these agents, and additional information about the results of pediatric studies. FDA also informed these manufacturers that it has determined that a Patient Medication Guide (MedGuide), which will be given to patients receiving the drugs to advise them of the risk and precautions that can be taken, is appropriate for these drug products. See the FDA Web site for more information.

- On October 24, 2005, the U.S. Food and Drug Administration (FDA) concluded that the overall risk of liver toxicity from Cylert and generic pemoline products outweighs the benefits of this drug. In May 2005, Abbott chose to stop sales and marketing of Cylert in the U.S. All generic companies have also agreed to stop sales and marketing of this product. Cylert, a central nervous system stimulant indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD), is considered second line therapy for ADHD because of its association with life threatening hepatic failure. Health care professionals who prescribe Cylert, or any of its generics, should transition their patients to an alternative therapy. Cylert will remain available through pharmacies and wholesalers until supplies are exhausted. No additional product will be available. See the FDA Web site for more information.

*Note from the National Guideline Clearinghouse and the American Academy of Child and Adolescent Psychiatry (AACAP): On October 3, 2005, AACAP pledged to work with the FDA on its September 29, 2005 advisory regarding Strattera (atomoxetine), to strengthen safeguards for the treatment of children and adolescents with Attention Deficit Hyperactivity Disorder (ADHD). See the AACAP Web site for the complete press release.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Substance use disorders (SUDs)

Note: The term "substance use disorders" encompasses both substance abuse and substance dependence under the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) category of substance-related disorders. Substance use disorders are defined for alcohol, amphetamine (or amphetamine-like), caffeine, cannabis, cocaine, hallucinogens, inhalants, nicotine, opioids, phencyclidine (or phencyclidine-like), and sedative, hypnotic, or anxiolytic agents.

GUIDELINE CATEGORY

Evaluation
Management
Screening
Treatment

CLINICAL SPECIALTY

Pediatrics
Psychiatry
Psychology

INTENDED USERS

Physicians
Social Workers
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

To describe the assessment and treatment of children and adolescents with substance use disorders (SUDs)

TARGET POPULATION

Children and adolescents with substance use disorders (SUDs)

INTERVENTIONS AND PRACTICES CONSIDERED

Evaluation/Screening

1. Screening for the use of alcohol and other substances of abuse:
    - Screening questions
    - Screening instruments such as CRAFFT; The Drug Use Screening Inventory - Adolescents (DUSI-A); Problem Oriented Screening Instrument for Teenagers (POSIT); Personal Experience Screening Questionnaire (PESQ)
2. Formal evaluation of quantity and frequency of use and consequences of use for each substance and determination if youth meets criteria for substance use disorder (SUD)
    - Obtaining information from the adolescent, parent(s) or other caregivers, other family members, school, any involved social agencies, and previous treatment records
    - Detailed assessment of the adolescent's substance use behavior
    - Obtaining a comprehensive developmental, social, and medical history
3. Use of toxicological tests to monitor substance use both during and after treatment
    - Urine screening
    - Blood screening
    - Hair samples

4. Thorough evaluation of comorbid psychiatric disorders

Management/Treatment

1. Provision of care in the least restrictive setting that is safe and effective
2. Inclusion of family therapy or significant family/parental involvement as a component of treatment of SUDs
3. Pharmacotherapy
    - Medications used to target alcohol-related cravings (e.g., naltrexone, acamprosate, ondansetron)
    - Aversion therapy (e.g., disulfiram)
    - Medications used to treat alcohol, benzodiazepine, or opiate withdrawal (e.g., benzodiazepines for alcohol, clonidine, and buprenorphine for opiate withdrawal)
4. Peer support
5. Twelve-step approach; self-help groups including Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) as adjunctive therapy
6. Programs/interventions with comprehensive services (i.e., vocational counseling, recreational activities, and medical services)
7. Appropriate treatment of patients with comorbid psychiatric disorders and SUDs
    - Cognitive-behavioral (CBT) modalities
    - Pemoline* and bupropion (attention deficit hyperactivity disorder)
    - Fluoxetine (depression)
    - Lithium and serotonin reuptake inhibitors (mood disorders)

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General Management Strategies

1. Provide appropriate level of confidentiality during assessment and treatment
2. Provision of aftercare programs

MAJOR OUTCOMES CONSIDERED

- Achieving and maintaining abstinence from substance use
- Criminal involvement
- School performance
- Harm reduction (a reduction in the use and adverse effects of substances, a reduction in the severity and frequency of relapses, and improvement in one or more domains of the adolescent's functioning)

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The list of references for this parameter was developed by searching PsycINFO, MedLine, and Psychological Abstracts; by reviewing the bibliographies of book chapters and review articles; by asking colleagues for suggested source material; and from the previous version of this parameter. The searches conducted in March 2003 used the following text words: substance abuse, adolescents, and treatments. The search covered the period 1990 to 2003 and yielded about 400 articles. Each of these references was reviewed, and only the most relevant or representative were included in this document.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Each recommendation in this parameter is identified as falling into one of the following categories of endorsement, indicated by an abbreviation in brackets following the statement. These categories indicate the degree of importance or certainty of each recommendation.

[MS] "Minimal Standards" are recommendations that are based on substantial empirical evidence (such as well-controlled, double-blind trials) or overwhelming clinical consensus. Minimal standards are expected to apply more than 95% of the time (i.e., in almost all cases). When the practitioner does not follow this standard in a particular case, the medical record should indicate the reason.

[CG] "Clinical Guidelines" are recommendations that are based on empirical evidence (such as open trials, case studies) and/or strong clinical consensus. Clinical guidelines apply approximately 75% of the time. These practices should always be considered by the clinician, but there are exceptions to their application.

[OP] "Options" are practices that are acceptable, but not required. There may be insufficient empirical evidence to support recommending these practices as minimal standards or clinical guidelines. In some cases they may be the perfect thing to do, but in other cases they should be avoided. If possible, the practice parameter will explain the pros and cons of these options.

[NE] "Not endorsed" refers to practices that are known to be ineffective or contraindicated.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This parameter was reviewed at the member forum at the 2002 annual meeting of the American Academy of Child and Adolescent Psychiatry (AACAP). During January to April 2004 a consensus group reviewed and finalized content of this practice parameter. The consensus group consisted of representatives of relevant American Academy of Child and Adolescent Psychiatry components as well as independent experts. This practice parameter was approved by the American Academy of Child and Adolescent Psychiatry Council in June 2004. A group of invited experts also reviewed the parameter.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Recommendations are identified as falling into one of four categories of endorsement. These categories, which are defined at the end of the "Major Recommendations" field, indicate the degree of importance or certainty of each recommendation.

Confidentiality

Recommendation 1: The clinician should observe an appropriate level of confidentiality for the adolescent during the assessment and treatment [MS].

Adolescents are more likely to provide truthful information if they believe their information, at least detailed information, will not be shared. Prior to the adolescent interview, the clinician should review exactly what information the clinician is obliged to share and with whom. Although it is obvious to the clinician that a court-ordered evaluation means a full report to the judge or probation officer, the adolescent may not be aware of this. The clinician should explicitly inform the adolescent of this requirement. Typically, a clinician should inform the adolescent that a threat of danger to self or others will force the clinician to inform a responsible adult, usually the parents. The clinician should be knowledgeable about local and Federal laws that limit what information may be released. Most states have confidentiality laws that restrict the information that the clinician is allowed to share with anyone unless the adolescent provides consent. This includes information about deviant behavior such as selling drugs, who sells the adolescent drugs, and peer behaviors. The clinician should encourage and support the adolescent's revealing the extent of substance use and other problems to parents. In other cases, the clinician should discuss what information the adolescent will allow the clinician to reveal such as a general recommendation for treatment or impressions rather than a detailed report of specific deviant and substance use behaviors.

Screening

Recommendation 2: The mental health assessment of older children and adolescents requires screening questions about the use of alcohol and other substances of abuse [MS].

In the face of problems in one or more domains of adolescent functioning, clinicians and educational professionals who work with youth often need to screen for the need for more comprehensive evaluation. At the very least, screening involves asking about substance use. Asking about quantity and frequency, the presence of adverse consequences of use, and the adolescent's attitude toward use are basic lines of screening inquiry. Several examples of screening instruments with established psychometric properties are listed in Table 1 in the original guideline document.

Evaluation

Recommendation 3: If the screening raises concerns about substance use, the clinician should conduct a more formal evaluation to determine the quantity and frequency of use and consequences of use for each substance used and whether the youth meets the criteria for substance use disorder(s) (SUDs) [MS].

The goal of the evaluation is to determine whether the adolescent is using one or more substances, what effects substance use has on various domains of the adolescent's psychosocial functioning, and whether the problem fits diagnostic criteria for substance abuse or dependence. To be considered a disorder, substance use must produce some level of dysfunction in one or more domains of the adolescent's life. These include psychiatric/behavioral, family, school/vocational, recreational/leisure, and medical domains. Because of the covert nature of substance use, optimal assessment often requires information from a variety of sources including the adolescent, parents (or other caregivers), other family members, school, any involved social agencies, and previous treatment records.

The attitude of the clinician should be nonjudgmental and flexible regarding the order of the interview elements in order to insure a valid report of substance use and associated problems.

The parent should be able to provide information about a family history of SUDs and other psychiatric disorders, family functioning, stressors and supports, as well as community resources and risks.

Detailed assessment of the adolescent's substance use behavior is an essential element of the interview. Inquiry into patterns of use should include information about the age at onset and progression of use for specific substances; circumstances, frequency, and variability of use; and the types of agents used. The clinician should ask about both direct and indirect consequences of use in the domains of family, school/vocational, social, and psychological functioning and medical problems. The interviewer should also inquire about the context of use, which pertains to the adolescent's view of substance use, the adolescent's expectancies of use, the usual times and places of substance use, peer attitudes and use patterns, common behavioral or emotional antecedents and consequences of use, and the adolescent's overall social milieu. Such an inquiry can take the form of a functional analysis, considering both antecedents and consequences of the substance use behaviors. Finally, the clinician should ask about the adolescent's view of his or her substance use as a potential problem, document past or current attempts to control or stop substance use, and review the criteria for substance abuse and dependence (substance-specific). Evaluating the adolescent's readiness for treatment or stage of change may help determine the initial treatment goals or level of care.

The differential diagnosis of adolescent SUDs requires consideration that the reported domains of dysfunction attributed to substance use may actually be due to premorbid or concurrent problems such as disruptive behavior disorders, family issues, or academic problems. The frequent comorbidity of SUDs and other psychiatric disorders necessitates a comprehensive review of past and present psychopathology including a review of psychiatric symptoms and treatment history.

The interview with the adolescent also includes elements common to all assessments of emotional and behavioral problems of adolescents. A comprehensive developmental, social, and medical history is a part of any complete assessment involving adolescents. Particularly important is a review of human immunodeficiency virus (HIV) risk factors including sexual and other high-risk behaviors. Clinicians may use a variety of structured interviews and rating scales with established psychometric properties to supplement interview information (see Table 2 in the original guideline document for examples).

Recommendation 4: Toxicology, through the collection of bodily fluids or specimens, should be a routine part of the formal evaluation and ongoing assessment of substance use both during and after treatment [MS].

Toxicological tests of bodily fluids, usually urine but also blood, and hair samples to detect the presence of specific substances should be part of the formal evaluation and the ongoing assessment of substance use (see Table 3 in the original guideline document). The optimal use of urine screening requires proper collection techniques including visualization of obtaining the sample, evaluation of positive results, and a specific plan of action should the specimen be positive for the presence of substance(s). The clinician should establish rules regarding the confidentiality of the results prior to testing. Because of the limited time a drug will remain in the urine and possible adulteration, a negative urine does not indicate that the youngster does not use drugs.

Treatment

Recommendation 5: Adolescents with SUDs should receive specific treatment for their substance use [MS].

Based on the combination of empirical research and current clinical consensus, the clinician dealing with adolescents with SUDs should develop a treatment plan that utilizes modalities that target: (1) motivation and engagement; (2) family involvement to improve supervision, monitoring, and communication between parents and adolescent; (3) improved problem solving, social skills, and relapse prevention; (4) comorbid psychiatric disorders through psychosocial and/or medication treatments; (5) social ecology in terms of increasing prosocial behaviors, peer relationships, and academic functioning; and 6) adequate duration of treatment and follow up care.

Recommendation 6: Adolescents with SUDs should be treated in the least restrictive setting that is safe and effective [MS].

Treatment of adolescents with SUDs can take place at one of several levels of care, reflecting intensity of treatment and restriction of movement. Factors affecting the choice of treatment setting include the following: (1) the need to provide a safe environment and the ability of the adolescent to care for himself; (2) motivation and willingness of the adolescent and his family to cooperate with treatment; (3) the adolescent's need for structure and limit-setting that cannot be provided in a less restrictive environment; (4) the existence of additional medical or psychiatric conditions; (5) the availability of specific types of treatment settings for adolescents; (6) the adolescent's and his family's preferences for a particular setting; and (7) treatment failure in a less restrictive setting or level of care.

Although residential programs, including therapeutic communities, have a place in the range of setting options, community intervention settings, if feasible, may offer optimal generalization of treatment gains. Even in the community, alternative sites such as home and school are being increasingly used.

Recommendation 7: Family therapy or significant family/parental involvement in treatment should be a component of treatment of SUDs [MS].

Family therapy is the most studied modality in the treatment of adolescents with SUDs. Based on the limited number of comparative studies, outpatient family therapy appears to be superior to other forms of outpatient treatment. Among the forms of family therapy having support based on controlled studies are functional family therapy, Multisystemic Therapy (MST), family systems therapy, and Multidimensional Family Therapy. An integrated behavioral and family therapy model that combines a family systems model and cognitive- behavioral therapy also appears efficacious. Despite the importance of family interventions, treatment can be effective without participation of the adolescent. Similarly, interventions with the adolescent alone (e.g., CBT or CBT plus MET) are also effective.

Recommendation 8: Treatment programs and interventions should develop procedures to minimize treatment dropouts and to maximize motivation, compliance, and treatment completion [CG].

Treatment completion is the treatment variable most consistently related to positive outcome. Related variables are motivation and compliance, which are also related to better outcomes. Adolescent perceptions can also contribute to whether the youth will be engaged in treatment; this suggests that specialized, adolescent-focused engagement interventions are necessary.

Modifications of motivational interviewing or enhancement techniques for adolescents have shown promise for both evaluation and treatment based on limited treatment studies. This nonjudgmental, nondirective strategy is designed to move the adolescent to a "stage of change" in which the youngster is more receptive to treatment or behavior change. Motivational interviewing and other brief interventions may serve to heighten motivation, increase self-efficacy, and provide personalized feedback and education tailored to specific substances and comorbid problems such as psychiatric disorders.

Specific engagement procedures have been incorporated as part of many family-based interventions. Other family-based treatments such as multidimensional family therapy and MST also have strong engagement goals and components.

Recommendation 9: Medication can be used when indicated for the management of craving and withdrawal and for aversion therapy [OP].

Medications used to target alcohol-related cravings (e.g., naltrexone, acamprosate, ondansetron) are increasingly used among adults and have been effective in case reports in adolescents. Their efficacy in adolescents has yet to be tested in controlled trials. These and aversive agents such as disulfiram could be considered for use in treatment-resistant adolescents.

Similarly, the use of medications to treat alcohol, benzodiazepine, or opiate withdrawal using such medications such as benzodiazepines (alcohol), or clonidine and buprenorphine (opiates) is not based on empirical research in adolescents but rather on research and experience with adults. Clinicians should use caution in considering pharmacological treatment for adolescents with comorbid SUDs and psychiatric disorders. The presence of SUDs or substance use may increase the potential for intentional or unintentional overdose with certain psychotropic medications, especially in combination with some substances of abuse.

Recommendation 10: Treatment should encourage and develop peer support, especially regarding the nonuse of substances [CG].

Having a supportive environment, especially parents and peers who do not use substances, is important for optimal outcomes.

A controversial element of traditional treatment programs is the widespread use of group treatment. There is substantial evidence that group treatment can have significant negative effects on outcomes. Emerging data suggest this iatrogenic effect may be limited to more deviant, conduct-disordered youth who nevertheless make up a substantial portion of the adolescent SUD treatment population. Other studies show positive effects for group modalities. Clinicians should take caution when forming groups for treatment and should consider alternative family-based or other modalities for more deviant youth.

Recommendation 11: Twelve-step approaches may be used as a basis for treatment. Attendance at Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) groups comprise an adjunct to professional treatment of SUDs and should be encouraged [CG].

Twelve-step programs can be defined as having adolescents work on specific steps toward recovery, attendance at self-support groups (AA or NA), and obtaining the assistance of a sponsor who is another person in recovery from substance use problems. Developmentally appropriate, specific twelve-step programs and self-support groups offer several benefits including a recovering (i.e., non-substance-using) peer group, available sponsors, and other types of support. Although 12-step programs may be effective for many adolescents, they have not been subject to controlled clinical trials.

Recommendation 12: Programs/interventions should attempt to provide comprehensive services in other domains (e.g., vocational, recreational, medical, family, and legal) [CG].

Programs with more comprehensive services such as vocational counseling, recreational activities, and medical services (including birth control) have better outcomes than programs without those services. As per the success of MST, programs that deal with the social ecology or total life circumstances of the adolescent are likely to produce more lasting benefits than those that do not.

<u>Comorbidity</u>

Recommendation 13: Adolescents with SUDs should receive thorough evaluation for comorbid psychiatric disorders [MS].

Significant rates of adolescents with coexisting SUDs and psychiatric disorders (disruptive behavior disorders, mood disorders, and anxiety disorders) are reported in both clinical and general populations. Certain psychiatric disorders such as disruptive behavior disorders and depressive disorders may increase the risk for the development of SUDs. Although researchers and clinicians have proposed the concept of adolescents using illicit substances as a form of self-medication for dysphoria or other psychiatric symptoms no definitive studies are available. Furthermore, the comorbidity of psychiatric disorders - particularly conduct disorder and, to a lesser extent, major depressive disorder - may have an effect on substance use and related problems both at baseline and at follow-up and may impair an adolescent's ability to effectively engage in treatment. Evidence suggests that depression increases the rate and rapidity of relapse. When compared with non-comorbid youth with SUDs, the 63% of youth with comorbid disorders were more likely to be alcohol or other drug dependent and have more problems with family, school, and criminal involvement; they were more likely to use marijuana and hallucinogens and engage in delinquent behavior in the 12 months after treatment.

Disruptive behavior disorders are the most common psychiatric disorders diagnosed in adolescents with SUDs. Conduct disorder, including the component of aggression, usually precedes and accompanies adolescent SUD. Attention deficit hyperactivity disorder (ADHD) is also often present in youth with SUDs. Several studies have also linked SUDs with learning disabilities and sensory processing problems in adolescents.

Mood disorders, particularly depression, frequently have onset both preceding and consequent to the onset of substance use and SUDs in adolescents. The prevalence of depressive disorders in these studies of clinical populations ranged from 24% to more than 50%. SUDs among adolescents are also a risk factor for suicidal behaviors, including ideation, attempts, and completed suicide.

A number of studies of clinical populations show high rates of anxiety disorders, especially posttraumatic stress disorder and social phobia, among youth with SUDs, ranging from 7% to more than 40%. Bulimia nervosa is also frequently associated with adolescents having SUDs. SUDs are very common among individuals, especially young and chronically impaired, who have a diagnosis of schizophrenia.

Recommendation 14: Comorbid conditions should be appropriately treated [MS].

It is essential to treat psychiatric disorders that are comorbid with SUDs. Although the effects of integrated mental health and SUD treatment awaits more empirical study, the optimal treatment of adolescents with SUD and psychiatric comorbidity presumably involves an integration of treatment modalities rather than merely concurrent or consecutive treatment with specific modalities for either SUD or psychiatric disorder(s).

Many cognitive-behavioral (CBT) modalities effective with adolescents with conduct disorder also are relevant for youth with coexisting SUDs. CBT can include elements directed toward substance use such as relapse prevention but also generic issues such as social skills, anger control, and problem-solving.

Recent emerging research and experience suggest that pharmacotherapy can be used safely and effectively in adolescents with SUDs. Open trials with pemoline* and bupropion for ADHD and fluoxetine for depression in a population of drug-dependent delinquents have shown promise. More recently, a double-blind, placebo-controlled trial of a stimulant medication demonstrated the efficacy of medication improving ADHD symptoms in adolescents with comorbid ADHD and SUD. This study also demonstrated that medication treatment of ADHD alone, without specific SUD or other psychosocial treatment, did not decrease substance use. Lithium, in a randomized controlled trial, and serotonergic reuptake inhibitors, in open trials, have produced significant improvements in adolescents with SUDs and comorbid mood disorders.

Some commonly used pharmacological agents, such as psychostimulants and benzodiazepines, have inherent abuse potential. The risk of abuse of a therapeutic agent either by the adolescent, his peer group, or family members should prompt a thorough assessment of the risk of this outcome (e.g., history of abuse of the agent, family/parental history of substance abuse or antisocial behavior). Often, parental or adult supervision of medication administration can alleviate concerns about potential abuse. The clinician should also consider alternative agents to psychostimulants, such as atomoxetine or bupropion, with a lower potential for abuse. The newer long-acting stimulant preparations may offer less potential for abuse or diversion due to their form of administration and the ability to more easily monitor and supervise once-a-day dosing. However, their abuse potential has yet to be fully ascertained. Although many anxiety symptoms or disorders in adolescents can be treated successfully with psychosocial methods such as behavior therapy, the use of selective serotonin reuptake inhibitors, tricyclic antidepressants, or buspirone is preferred over the use of benzodiazepines.

Aftercare

Recommendation 15: Programs and interventions should provide or arrange for post-treatment aftercare [CG].

After the acute treatment for substance use, ongoing attention should be paid to comorbid psychopathology and other comprehensive needs of the adolescent and his family. Self-support groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are often an element of aftercare.

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[CG] "Clinical Guidelines" are recommendations that are based on empirical evidence (such as open trials, case studies) and/or strong clinical consensus. Clinical guidelines apply approximately 75% of the time. These practices should always be considered by the clinician, but there are exceptions to their application.

[OP] "Options" are practices that are acceptable, but not required. There may be insufficient empirical evidence to support recommending these practices as minimal standards or clinical guidelines. In some cases they may be the perfect thing to do, but in other cases they should be avoided. If possible, the practice parameter will explain the pros and cons of these options.

[NE] "Not endorsed" refers to practices that are known to be ineffective or contraindicated.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated. In general, the recommendations of this parameter are based on a thorough review of the literature as well as clinical consensus.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Accurate diagnosis and effective treatment of children and adolescents with substance use disorders resulting in improved outcomes:

- Abstinence from substance use
- Reduced severity and frequency of relapses
- Improvement in one or more domains of the adolescent's functioning (e.g. academic performance or family functioning)

POTENTIAL HARMS

Medications used for the management of craving and withdrawal and for aversion therapy

Clinicians should use caution in considering pharmacological treatment for adolescents with comorbid substance use disorders (SUDs) and psychiatric disorders. The presence of substance use disorders or substance use may increase the potential for intentional or unintentional overdose with certain psychotropic medications, especially in combination with some substances of abuse.

Group treatment

There is substantial evidence that group treatment can have significant negative effects on outcomes. Emerging data suggest this iatrogenic effect may be limited to more deviant, conduct-disordered youth who nevertheless make up a substantial portion of the adolescent SUD treatment population. Other studies show positive effects for group modalities. Clinicians should take caution when forming groups for treatment and should consider alternative family-based or other modalities for more deviant youth.

Pharmacological treatment for comorbid conditions

Some commonly used pharmacological agents, such as psychostimulants and benzodiazepines, have inherent abuse potential. The risk of abuse of a therapeutic agent either by the adolescent, his peer group, or family members should prompt a thorough assessment of the risk of this outcome (e.g., history of abuse of the agent, family/parental history of substance abuse or antisocial behavior).

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

American Academy of Child and Adolescent Psychiatry (AACAP) practice parameters, based on evaluation of the scientific literature and relevant clinical consensus, describe generally accepted approaches to assess and treat specific disorders or to perform specific medical procedures. These parameters are not intended to define the standard of care; nor should they be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The clinician - after considering all the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources - must make the ultimate judgment regarding the care of a particular patient.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Work Group on Quality Issues. Bukstein OG. Practice parameter for the assessment and treatment of children and adolescents with substance use disorders. Washington (DC): American Academy of Child and Adolescent Psychiatry (AACAP); 2004. 25 p. [112 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1997 (revised 2004)

GUIDELINE DEVELOPER(S)

American Academy of Child and Adolescent Psychiatry - Medical Specialty Society

SOURCE(S) OF FUNDING

American Academy of Child and Adolescent Psychiatry

GUIDELINE COMMITTEE

Work Group on Quality Issues

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

This parameter was developed by: Oscar G. Bukstein, M.D.

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Members of the consensus group were asked to identify any conflicts of interest they may have with respect to their role in reviewing and finalizing the content of this practice parameter. One or more of the consensus group members were on the speakers bureau for one or more of the following pharmaceutical companies: Abbott, Eli Lilly, GlaxoSmithKline, Janssen, Ortho-McNeil, Pfizer, Shire, and Wyeth.

GUIDELINE STATUS

This is the current release of the guideline.

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GUIDELINE AVAILABILITY

Electronic copies: Available (to members only) from the American Academy of Adolescent and Child Psychiatry (AACAP) Web site.

Print copies: Available from AACAP, Communications Dept., 3615 Wisconsin Ave, NW, Washington, DC 20016. Additional information can be obtained through the AACAP Publication Catalog for Parameters.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

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